

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155446		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/05/2012	
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804			
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F0000	<p>This visit was for the investigation of Complaint IN00108978.</p> <p>Complaint IN00108978-Substantiated. Federal/state deficiencies related to the allegation are cited at F309, F502, F505, and F514.</p> <p>Survey dates: June 1, 4, 5, 2012</p> <p>Facility number: 000476 Provider number: 155446 Aim number: 100290870</p> <p>Survey team: Ann Armey, RN</p> <p>Census bed type: SNF/NF: 130 Total: 130</p> <p>Census payor type: Medicare: 23 Medicaid: 72 Other: 35 Total: 130</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>		F0000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	Quality review completed 6/6/12 Cathy Emswiller RN						

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on observation, interviews, and record review, the facility failed to obtain an antibiotic after it was ordered resulting in a two day delay of treatment. This deficiency affected 1 of 3 resident with infections, whose treatments were reviewed, in a sample of 4. (Resident #E)</p> <p>Findings include:</p> <p>The clinical record of Resident #E was reviewed on 6/4/12 at 2:00 p.m., and indicated the resident was admitted to the facility on 3/4/11, with diagnoses which include but were not limited to, chronic obstructive pulmonary disease and a history of DVT (Deep Vein Thrombosis).</p> <p>Nursing notes, dated 5/21/12 at 2:00 p.m., indicated " residents (sic) left calf reddened, inflamed and warm to touch..." The note indicated the medical doctor would be updated.</p> <p>Physician orders, dated 5/21/12, indicated the resident was to receive Levaquin (an</p>		F0309	<p>1) Resident E completed the antibiotic therapy ordered without adverse effect. The facility became aware of this isolated deficient practice prior to the date of survey. The nurse responsible for the delayed transcription of the antibiotic order was educated by the Director of Staff Development regarding physician orders and the use of the Emergency Drug Kit (EDK). 2) The Unit Managers reviewed all resident's current Medication Administration Records for any deficient practice related to the delay of prescribed medication orders. Any further discrepancy found, will follow through with notification of the physician for proper reporting of delay of treatment with new orders received, if indicated. Any nurse responsible for a discrepancy will receive disciplinary action. 3) In-servicing was provided by the Director of Staff Development to the nursing staff reviewing "Pharmacy Services Guidelines" (Attachment A), "Emergency Drug Supply" (AttachmentB), and "Processing Physician Orders"</p>		06/22/2012	

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	<p>antibiotic used to treat infections) 250 mg every day for five days due to "L (left) shin warm & (and) pink Hx (History) of DVT & cellulitis."</p> <p>The May 2012 MAR (Medication Administration Record) indicated the Levaquin order was noted on 5/22/12 and was first administered on 5/23/12, two days after it was ordered.</p> <p>On 6/4/12 at 3:30 p.m., Resident #E's lower left leg was observed with Unit Manager #11. The left lower leg was not swollen or painful. Both of Resident #E's lower legs had a discoloration of the skin which the Unit Manager indicated was normal for the resident.</p> <p>On 6/5/12 at 9:30 a.m. Unit Manager #11 indicated she talked to the nurse who had worked when the Levaquin order was received. The Unit Manager indicated the nurse "missed" the order and it was not transcribed on to the MAR until the next day.</p> <p>The Unit Manager indicated the Levaquin was available in the EDK (Emergency Drug Box) but the nurse did not check the EDK and as a result, the medication was not started until two days after it was ordered.</p> <p>This Federal tag relates to Complaint</p>			<p>(Attachment C). A listing of medications available in the EDK was placed in each medication administration record. 4) Audits will occur daily by the unit managers utilizing the "Daily Medical Record Audit/DNS Report" (Attachment D). Any adverse results from the audit will result in disciplinary action for the offending nurse with educational resources provided, if indicated. Additionally, the results will be discussed monthly during the QA&A meeting for a minimum of 6 months. Audits must be 100% accurate, thereafter, for three months for auditing to cease.5) All education requirements for corrective action will be completed by June 22, 2012</p>			

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	IN00108978. 3.1-37(a)						

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F0502 SS=D	<p>483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>Based on interviews and record review, the facility failed to obtain a urinalysis and hemo cult stool tests in a timely manner. This deficiency affected 2 of 4 residents whose lab tests were reviewed in a sample of 4. (Resident #B and Resident #C)</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident #B was reviewed on 6/1/12 at 1:30 p.m. and indicated the resident was admitted to the facility on 3/19/12, with diagnoses included but were not limited to, left arm fracture and atrial fibrillation. The resident was admitted to the hospital on 5/11/12, returned to the facility on 5/15/12 and was readmitted to the hospital on 5/20/12.</p> <p>The MDS (Minimum Data Set) assessment, dated 5/4/12, indicated Resident #B had no cognitive impairment and was continent of bowel and bladder. The MDS assessment indicated the resident required extensive assistance of two for toileting.</p>	F0502	<p>1) A review of current standards was completed. Education was provided by the Director of Staff Development to those involved with Resident B and Resident C. 2) During the implementation of guidelines and guidance, all current lab orders were reviewed by the unit managers. Records for any deficient practice related to the delay of obtaining ordered labs will follow through with notification of the physician for proper reporting of delay of treatment with new orders received, if indicated. Any nurse responsible for a discrepancy will receive disciplinary action. 3) A review of current "Lab Audit Operating Standard Guidelines" was completed (<i>Attachment E</i>). It was determined that the facility was utilizing the audit tool weekly, instead utilizing the audit daily (<i>Attachment F</i>). Unit Managers will now be completing the audit daily. Additionally, guidance was given to the floor nurses to ensure all physician lab orders are completed timely and prevent any delayed implementation of prescribed orders (<i>Attachment G</i>). 4) The Daily Lab Audit will be forwarded to the Director of Nursing for review. Any adverse</p>		06/22/2012		

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	<p>On 5/5/12 at 4:00 p.m., physician orders indicated resident #B was to have a urinalysis with a culture and sensitivity.</p> <p>There was no documentation a urine specimen was obtained on 5/5/12.</p> <p>On 5/6/12 at 12:00 p.m., nursing notes indicated the nurse attempted to obtain a urine specimen but the resident requested the straight catheterization be done later.</p> <p>On 5/6/12 at 4:00 p.m. (24 hours after it had been ordered), nursing notes indicated "res (resident) UA (urinalysis) obtained per straight cath (catheterization)..." The nursing notes indicated Resident #B had experienced a decline in her functional level.</p> <p>The urinalysis report indicated the urine specimen was received by the laboratory on 5/7/12 at 12:19 p.m. (20 hours after it was collected).</p> <p>On 5/8/12 at 3:30 p.m., nursing notes indicated three plus bacteria were present in Resident #B's urine. The nursing note indicated the culture and sensitivity results were still pending.</p> <p>On 5/8/12 (no time listed), physician orders indicated the resident was to</p>				<p>results from the audit will result in disciplinary action for the offending nurse with educational resources provided, if indicated. Additionally, the results will be discussed monthly during the QA&A meeting for a minimum of 6 months. Audits must be 100% accurate, thereafter, for three months for auditing to cease. 5) All education requirements for corrective action will be completed by June 22, 2012.</p>		

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	<p>receive Cipro (an antibiotic medication used to the urinary tract infection) 250 mg twice daily for five day.</p> <p>On 5/9/12, four days after the urinalysis was ordered, the final culture and sensitivity report indicated Resident #B's urine cultured positive for Enterococcus. On 5/10/12, the Cipro was discontinued and Levaquin, 250 mg every day, was ordered.</p> <p>An Acute Hospital Transfer Record indicated Resident #B was transferred to the hospital on 5/11/12 at 6:30 p.m. with increased confusion, and decreased urinary output.</p> <p>The Hospital Discharge Summary, dated 5/15/12, indicated Resident #B was treated in the hospital for altered mental status, and a urinary tract infection.</p> <p>On 6/4/12, at 9:00 a.m., Unit Manager #10, who worked on Resident #B's unit was interviewed. She indicated Resident B's family had mistakenly been told that a urinalysis was ordered on 5/4/12 but it was not actually ordered until 5/5/12. She indicated she was not sure why the urine specimen was not obtained on 5/5/12 but on 5/6/12, the resident did refuse to have the straight catheterization done because</p>						

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	<p>she wanted it done later.</p> <p>Unit Manager #10 indicated, after the urine specimen was obtained on 5/6/12, the laboratory was contacted to pick up the specimen but they never actually came to get the urine until 5/7/12. The Unit Manager indicated the physician ordered the antibiotic on 5/8/12, because the family requested it, pending the culture and sensitivity report.</p> <p>On 6/5/12 at 9:00 a.m., Unit Manager #12 was interviewed and indicated there was no policy regarding time frames for obtaining laboratory tests. She indicated it was accepted practice to have laboratory tests completed promptly after they were ordered.</p> <p>2. The clinical record of Resident #C indicated she was admitted to the facility on 4/16/12, with a diagnoses which included but was not limited to, right hip replacement on 4/11/12.</p> <p>Admission orders, dated 4/16/12, indicated the resident was to receive Coumadin (a medication used to prevent blood clots) 4 mg every day.</p> <p>A complete blood count laboratory report, dated 4/17/12, indicated the resident had a low hemoglobin of 8.2 (Normal Range</p>						

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	<p>12-15.5) and a low hematocrit of 25.8 (Normal Range 35-48).</p> <p>On 4/17/12, physician orders indicated the resident was to receive two units of packed red blood cells and was to have three hemo cult stool tests completed. There was no documentation the hemo cult stool tests were done.</p> <p>On 6/5/12 at 9:30 a.m., Unit Manager #10 indicated the hemo cult order was not noted properly and as a result, the tests were not done.</p> <p>This Federal tag relates to Complaint IN00108978.</p> <p>3.1-49(a)</p>						

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F0505 SS=D	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings.</p> <p>Based on interviews and record review, the facility failed to notify the physician when a laboratory report was received. This deficiency affected 1 of 4 residents, reviewed for notification of the physician, in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>The closed clinical record of Resident #B was reviewed on 6/1/12 at 1:30 p.m. and indicated the resident was admitted to the facility with diagnoses which included but were not limited to, left arm fracture and atrial fibrillation. Resident #B was admitted to the hospital on 5/11/12, returned to the facility on 5/15/12 and was readmitted to the hospital on 5/20/12.</p> <p>The MDS (Minimum Data Set) assessment, dated 5/4/12, indicated Resident #B had no cognitive impairment and was continent of bowel and bladder. The MDS assessment indicated the resident required extensive assistance of two for toileting.</p> <p>On 5/5/12 at 4:00 p.m., physician orders indicated resident #B was to have a urinalysis with a culture and sensitivity.</p>		F0505	<p>1) A review of current standards was completed. Education was provided by the Director of Staff Development to those involved with Resident B.</p> <p>2) During the implementation of guidelines and guidance, all current lab orders were reviewed by the unit managers. Records for any deficient practice related to the delay of obtaining ordered labs will follow through with notification of the physician for proper reporting of delay of treatment with new orders received, if indicated. Any nurse responsible for a discrepancy will receive disciplinary action.</p> <p>3) A review of current "Lab Audit Operating Standard Guidelines" was completed (<i>Attachment E</i>). It was determined that the facility was utilizing the audit tool weekly, instead utilizing the audit daily (<i>Attachment F</i>). Unit Managers will now be completing the audit daily. Additionally, guidance was given to the floor nurses to ensure all physician lab orders are completed timely and prevent any delayed implementation of prescribed orders (<i>Attachment G</i>).</p> <p>4) The Daily Lab Audit will be forwarded to the Director of Nursing for review. Any adverse</p>		06/22/2012	

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	<p>On 5/6/12 at 4:00 p.m. nursing notes indicated a urine specimen was obtained.</p> <p>The report indicated the urinalysis results were faxed to the facility on 5/7/12 at 10:08 p.m.</p> <p>There was no documentation the physician was notified about the urinalysis results after they were faxed to the facility.</p> <p>On 5/8/12 at 3:30 p.m., nursing notes indicated three plus bacteria were noted in Resident #B's urine. The nursing note indicated the culture and sensitivity results were still pending.</p> <p>On 5/8/12 (no time listed), the physician's order indicated Resident #B was to receive Cipro (an antibiotic medication), for the urinary tract infection, 250 mg twice daily for five day.</p> <p>The May 2012 MAR (Medication Administration Record) indicated Resident #B received the first dose of Cipro on 5/8/12 at 8:00 p.m.</p> <p>On 5/9/12, the final culture and sensitivity report indicated Resident #B's urine cultured positive for Enterococcus.</p> <p>On 6/4/12 at 9:00 a.m., Unit Manager #10</p>				<p>results from the audit will result in disciplinary action for the offending nurse with educational resources provided, if indicated. Additionally, the results will be discussed monthly during the QA&A meeting for a minimum of 6 months. Audits must be 100% accurate, thereafter, for three months for auditing to cease.</p> <p>5) All education requirements for corrective action will be completed by June 22, 2012.</p>		

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	<p>indicated the physician should have been notified when the urinalysis report was faxed to the facility but there was no documentation the physician was notified until the following evening.</p> <p>On 6/5/12 at 10:15 a.m., Unit Manager #11 indicated there was no specific policy regarding the notification of the physician about laboratory results but it was expected that the nurses would notify the physician when pertinent laboratory test results were received.</p> <p>This Federal tag relates to Complaint IN00108978.</p> <p>3.1-49(f)(2)</p>						

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interviews and record review, the facility failed to document a skin assessment and documented a treatment that was not done. This deficiency affected 1 of 4 residents, whose records were reviewed, in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>1. The closed clinical record of Resident #B was reviewed on 6/1/12 at 1:30 p.m. and indicated the resident was admitted to the facility on 3/19/12, with diagnoses included but were not limited to, left arm fracture and atrial fibrillation. The resident was admitted to the hospital on 5/11/12, returned to the facility on 5/15/12 and was readmitted to the hospital on 5/20/12.</p>		F0514	<p>1) A review of the current standards, "Treatment Audit Operating Standard Guidelines" (Attachment H), and the "Skin Integrity Standard" (Attachment I) was completion. Upon review, it was determined that re-education was required of all nursing staff rather than revision of the standards. Education was provided to those involved with Resident B by the Director of staff Development.</p> <p>2) Skin assessments were conducted on all residents as delegated by the unit managers. No further deficiencies were found. Treatment records were reviewed.</p> <p>3) In-servicing was provided for all nursing staff by the Director of Staff Development reviewing the standards for treatments and skin integrity.</p> <p>4) The unit managers will utilize the "Treatment</p>		06/22/2012	

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	<p>The May 2012 MAR (Medication Administration Record) indicated Resident #B was receiving Coumadin. The May 2012 TAR (Treatment Administration Record) indicated the resident was to have knee high Ted hose on in the morning and off at bedtime.</p> <p>A late entry nursing notes, for 5/11/12 at 6:15 a.m., indicated the resident had a pink area to her left shin measuring 10 cm by 6 cm.</p> <p>There was no documentation the area was assessed after 6:15 a.m. on 5/11/12.</p> <p>An Acute Hospital Transfer Record indicated Resident #B was transferred to the hospital on 5/11/12 at 6:30 p.m.</p> <p>The hospital emergency room report, dated 5/11/12, indicated the resident had bruising to the lateral aspect of the left calf and a left lower leg hematoma. There was no documentation the bruise or hematoma were measured or that pictures were taken of the areas in the emergency room. A hospital laboratory report, dated 5/12/12 indicated the resident had an elevated PT (prothrombin time) of 87.1 (Normal range 10.4-12.5) and had an elevated INR (International Normalized Ratio) of 8.5 (normal range 2.-3).</p>		<p>Documentation/Weekly Audit" (Attachment J) to ensure completeness of documentation for skin issues and treatments. The Director of Nursing will review the audits for any adverse results. Any deviation from the policy will result in immediate disciplinary action and/or additional education. Additionally, the results will be discussed monthly during the QA&A meeting for a minimum of 6 months. Audits must be 100% accurate, thereafter, for three months for auditing to cease.</p> <p>5) All education requirements for corrective action will be completed by June 22, 2012.</p>				

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	<p>On 6/4/12 at 9:50 a.m., CNA #12, who worked on Resident B's unit on the day shift on 5/11/12, was interviewed. The CNA indicated, on 5/11/12, when she went in to put on Resident #B's Ted hose, the resident complained her left leg hurt. The CNA indicated the back of Resident #B's leg was "a little red" so she got the night nurse and the night nurse checked her leg. The CNA indicated she applied the Ted hose after the nurse checked Resident #B's leg.</p> <p>On 6/4/12 at 204 p.m., RN #13, who was the day nurse on Resident #B's unit on 5/11/12, was interviewed. She indicated the night nurse told her Resident #B had a red/pink area on the back of her left leg. RN #13 indicated she rolled the Ted hose down and checked the resident's left leg sometime on the afternoon of 5/11/12. RN #13 indicated she noted no bruising or hematoma but did observe a pink/red area on the back of the resident's calf. RN #13 further indicated she did not document the assessment of Resident #B's left lower leg.</p> <p>2. Resident #B returned to the facility from the hospital on 5/15/12.</p> <p>A non pressure skin condition report, dated 5/15/12, indicated the resident had a</p>						

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	<p>13.8 cm by 11.9 cm dark red purple bruise on her left lateral calf.</p> <p>On 5/16/12 and order was obtained to apply Kerlix to the left lateral calf.</p> <p>The May 2012 TAR indicated the Kerlix dressing was to be applied every shift. The Kerlix was documented as being applied on every shift, including on 5/19/12, during the evening shift and on 5/20/12 during the night an day shifts.</p> <p>On 5/19/12 at 10:15 p.m., nursing notes indicated "discoloration and fluid filled blister cont. (continues) to LLE (left lower extremity). Kerlix in place as ordered..."</p> <p>There was no further documentation regarding the lower left calf until 5/20/12 at 12:00 p.m., (14 hours later) when black eschar measuring 4.5 cm by 3 cm and a blood filled blister measuring 1 cm by 2cm were noted on the left calf.</p> <p>On 5/20/12 at 2:15 p.m., the Acute Hospital Transfer Record indicated resident was transferred to the hospital per family request.</p> <p>On 6/4/12 at 2:15 p.m., LPN #14, who documented she changed the Kerlix dressing on the both the evening and night</p>						

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	<p>shift on 5/19/12 through 5/20/12, was interviewed regarding the condition of Resident #B's lower left leg during the dressing changes.</p> <p>LPN #14 indicated she worked a 12 hour shift from 6:00 p.m. through 6:00 a.m. on 5/19-20/12. LPN #14 indicated she applied the Kerlix one time during the 12 hour shift. She was uncertain of the time of the dressing change but indicated and she documented her assessment of the lower left leg in the nursing notes when she changed the Kerlix.</p> <p>LPN #14 indicated she initialed on the TAR that she did the treatment two times (on the evening and night shift) but she actually only did the treatment one time during her twelve hour shift.</p> <p>Thus, it was documented that the Kerlix dressing was changed on the night shift when it actually was not changed.</p> <p>On 6/5/12 at 9:30 a.m., Unit Manager #11 was interviewed and indicated treatments should not be initialed if they are not done.</p> <p>This Federal tag relates to Complaint IN00108978.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>						

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